12.1.0 Definition

12.1.1 BadgerCare

BadgerCare (BC) is an expansion of Wisconsin's MA program. All general MA non-financial requirements (40.2.0) apply to BC in addition to those items listed in 12.3.0. Explain the BC program to each household that includes a potential BC client, and offer them an opportunity to apply for BC. Potential BC clients are:

- Children under age 19. For BC purposes, a child is defined as being under age 19. Marital status does not affect an individual's status as a child.
- Parents living with children under age 19.
- Spouses living with parents of children under the age of 19.

If a client fails all other full-benefit MA subprograms (24.2.0), test them for BC. They will be eligible for BC if they:

- Meet BC non-financial (12.3.0) and financial (12.4.0) tests.
- Are not eligible for any other full-benefit MA subprograms.

Full-benefit MA eligibility does not include those subprograms listed in 24.3.0.

12.1.2 BC Applicants

BC applicants are those who have not been eligible in the current or previous month for BC.

12.1.3 BC Recipients

BC recipients are those that have been eligible in the current or previous month for BC.

12.2.0 Application

Eligibility goes back to the first of the month of application in which all eligibility requirements were met. There is no three-month backdate period for BC.

12.3.0 Non-Financial Requirements

The following are BC specific non-financial requirements:

- Meet general MA non-financial requirements (40.2.0).
- A child under age 19, parents living with children under age 19, or a spouse living with parents of children

12.3.0 Non-Financial Requirements (cont.)

under the age of 19.

- Do not have health insurance coverage (12.3.4) now or in the three calendar months prior to the BC request.
- Do not have access to health insurance coverage (12.3.5) now or in the past 18 months.
- Pay a premium if the family income exceeds 150% of the FPL (30.11.0).

12.3.1 Deprivation

There is no requirement that a parent be the caretaker of a deprived child. Do not deny BC for failure to furnish or verify information necessary to establish deprivation.

12.3.2 Joint Custody

When the natural or adoptive parents of a child do not live together, and have joint custody, either parent can apply for BC. If both parents are applying, only one parent can be determined eligible at a time. See 3.3.2 if there is any question about who is the primary person, including if there is an arrangement where the minor spends equal time in each household.

12.3.3 Health Insurance Premium Payment (HIPP)

Cooperation with HIPP is a BC non-financial eligibility requirement (38.7.0).

12.3.4 Insurance Coverage

A person is ineligible for BC, when s/he:

1. Is covered or has been covered in the three calendar months prior to the BC request by any health insurance plan, **and**
2. The health insurance plan meets the standards of a Health Insurance Portability and Accountability Act (HIPAA) standard plan (38.2.0).

The policyholder does not need to live in the home. The plan can be individual or family coverage. The person or employer's share of the premium has no affect. Someone with coverage in a location other than where they are living is still insured. It does not matter if it is another county or another state.

12.3.4 Insurance Coverage (cont.)

Coverage includes employer based and any other health insurance coverage. It does not include MA, Medicare, Medicare Supplemental policies, HIRSP, WisconCare, General Relief, General Assistance, or Family Health Plan coverage. The Family Health Plan is a government sponsored safety net coverage run by Marshfield clinics.

12.3.4.1 Self-Employed

Consider self-employed people, including farmers, as covered by health insurance and if the:

1. Individual purchased a plan that covers him or herself, **or**

2. The business is incorporated and s/he is an employee of the corporation, and has health insurance through the corporation.

Good Cause - Good cause exists if the owner of any self-employment enterprise lost health insurance in the previous three months prior to the eligibility determination if:

1. The operation provides health insurance coverage to the individual, **and**

2. That operation drops health insurance coverage for **all** employees of the operation, **and**

3. The farm or self-employment operation lists the health insurance costs as a business expense/loss on their tax forms. The expense/loss must be listed on the self-employment tax forms.

This means that the self-employed person, who meets all the above criteria and who drops his/her health insurance coverage in the month prior to application for BC, does not have to wait three months before eligibility can begin.

12.3.4.2 Coverage Process

Collect insurance coverage information from the client and through CARES. EDS verifies insurance information.

If the client does not know if the non-custodial parent has a health insurance plan that provides coverage for anyone in the household, assume they do not have one.

If the client does not know if s/he or someone other than the non-custodial parent has health insurance, ask for the information and consider it questionable until s/he provides

12.3.4.2 Coverage Process (cont.)

the information.

CARES will send coverage information to EDS, only if the insurance information is complete in CARES. EDS will verify insurance coverage information. If EDS verifies insurance coverage exists, and sends that information to CARES. You will receive an alert if EDS finds that there is verified coverage through a HIPAA standard plan (38.2.0). Review the insurance information for accuracy, and in cases involving past coverage, check with the clients as to whether there was good cause for losing coverage. BC eligibility will end at the end of the month following adverse action for those clients with HIPAA insurance coverage currently in effect or in the three prior calendar months.

12.3.4.3 Coverage Good Cause Reasons

If a person has good cause for dropping or losing his/her employer provided insurance coverage in the previous three months, s/he may be eligible. Good cause reasons are:

1. Loss of employment, other than a voluntary termination.
2. Loss of employment due to the employee's incapacitation.
3. Change to a new employer that does not offer coverage.
4. End of COBRA continuation.
5. Coverage ends due to death, divorce or age.
6. Coverage ends due to reduced (voluntary or involuntary) hours of employment.
7. Discontinuation of health benefits to all employees by the client's employer. See 12.3.4.1 for self-employed.

If you have an unusual situation where coverage ended in the last three months for a reason beyond the control of the family, contact the DES Call Center. Medicaid staff will determine if good cause exists and the Call Center will notify you. It is not good cause if a person drops coverage because of the cost.

Clients who have lost their insurance coverage due to involuntary loss of employment, and meet all other eligibility requirements, are eligible for BC. Begin his/her BC eligibility the day after the last day of the insurance coverage or the

12.3.4.3 Coverage Good Cause Reasons (cont.)

application date, whichever is later.

If s/he opts to take COBRA coverage, do not begin his/her BC eligibility until the COBRA coverage has ended because it has reached the 18th month. Do not begin BC eligibility the day after COBRA coverage has ended if the coverage ended because of voluntary termination or the client did not pay the premiums.

12.3.5 Insurance Access

Clients are ineligible for BC if they have access to health insurance through a household member's employer. EDS verifies insurance access using the current employer's information from CARES. Insurance access means a family member living in the household is employed:

1. And can sign up for an employer-subsidized **family** health care plan which meets the HIPAA standard plan (38.2.0) definition, and for which the **employer pays 80% or more** of the cost of the premium for the plan. Consider all members of the household that could be covered by that employer's policy to have access; **or**

2. By a unit of state government and can sign up for the State's health care plan which meets the HIPAA standard plan (38.2.0) definition. Consider those who could be covered by the State's health care plan to have access. It does not matter if the plan is **family or individual**, or what premium amount that state government would pay.

Access includes the ability to sign up and be covered in the current month. It also includes if s/he had the ability to sign up and be covered in any or all of the 18 months prior to the application or redetermination of BC eligibility.

If the client had access any time in the past 18 months, those who had access are ineligible for 18 months.

There are three different situations to consider when determining whether access exists.

BC clients are not exempt from being required to sign up with an employer's health plan when members of the household receive MA or have other insurance coverage.

12.3.5.1 Current Access

If a family could sign up this month and be covered this month (employer pays 80% or more), then all members of the

12.3.5.1 Current Access (cont.)

family who could be covered are ineligible for BC.

Start of Ineligibility Period: Start the ineligibility period after giving timely notice.

Example. Tom applies September 10, 2001. EDS discovers in early October that Tom can enroll his family under his employer's health plan at any time and coverage would start immediately. He is given timely notice and closes at the end of October. The ineligibility period starts November 2001.

12.3.5.2 Past Access

If a family could have signed up (or been signed up for) and been covered through employer provided family coverage (at 80% or more) through the current employer in the past 18 months, they are ineligible.

Do not deny the group's eligibility based on access if anyone in the household was covered by MA (but not BC) or another health insurance plan at the time the group could have been enrolled in the employer's plan.

Start of Ineligibility Period: If a family could have signed up for family coverage through an employer group health plan, the members with access remain ineligible for 18 months from the month coverage could have started. The ineligibility period may cover a period when the client received BC. See the second example.

Example. Jim applies for BC in July 2001. In October 2000, Jim's employer had an open enrollment health insurance period with coverage starting in January 2001. He did not enroll. Jim's children were eligible for MA in October, so he remains eligible.

Example. Kim applies for BC in November 2000, and is approved. No one else in her household had MA eligibility or insurance coverage during the last three months. EDS finds in February 2001, Kim could have signed up with her employer's health plan in February 2000, and coverage would have been available March 2000. She did not sign up and will not get another chance to sign up until February 2002. The ineligibility period starts March 1, 2000 for Kim and the children. Do not consider the BC she received from November to February to be incorrect benefits.

12.3.5.2 Past Access (cont.)

Example. The same circumstances as the above, except the children were covered by health insurance in February 2000. The children's coverage allows Kim to be eligible.

Note: If Kim is still on BC next February, she will be required to sign up with the employer's plan, even if the children are on MA.

12.3.5.3 Future Access

If the family can sign up for coverage in which the employer pays 80% or more, but it does not start until a later date, s/he must sign up for the coverage. EDS monitors this and notifies you via CARES. If s/he does sign up, continue BC eligibility until the end of the month in which insurance coverage starts. Clients receive the full month to avoid gaps in coverage if a new policy starts after the first of the month.

Even if a client does not sign up for coverage that starts at a later date, continue BC eligibility until the end of the month in which insurance coverage could start.

Start of Ineligibility Period: Start the ineligibility period the month after access to coverage.

Example. Bob's employer offers health insurance in January. The coverage will not start until March 1st. Bob does not sign up. Bob's family remains BC eligible through March 31st. The ineligibility period starts April 1st.

12.3.5.4 Self-Employment

For self-employment operations in which the owner/operator is applying for BC, do not consider the coverage the operation provided in the past, or could provide, when determining if there is past access.

12.3.5.5 Access Process

Insurance access will be determined only by EDS. You will collect insurance access information from the client and through CARES. However, do not verify insurance access information for BC. Accept the client's statements in determining initial BC eligibility. Do not verify information concerning who could be covered in the household, or whether the coverage meets the HIPAA standards (38.2.0).

Persons who say they have access to employer subsidized-health plans remain eligible for BC until EDS verifies who in the household has access. EDS obtains any insurance

12.3.5.5 Access Process (cont.)

information that is needed from the employer directly.

Ask the client if s/he has access to a group health plan. If s/he does, CARES sends that information to EDS upon confirmation. EDS then sends an Employer Verification of Insurance Coverage (EVIC) form to the employer who completes it and gives it back to EDS. If a family member does have insurance access, s/he will become ineligible. The case runs through adverse action and closes at the end of the month.

12.3.5.6 Access Good Cause Reasons

Good cause reasons for not having insurance access are:

1. Loss of employment.
2. Change to a new employer that does not offer access.
3. Access ends due to death, divorce or age.
4. Reduced hours (voluntary or involuntary) lead to loss of insurance access.

.

For clients who have lost their insurance access due to involuntary loss of employment, and meet all other eligibility requirements, begin his/her BC eligibility the day after the last day of the insurance access. A client who declined to take COBRA coverage at the time of the involuntary loss of employment did not have access to insurance.

12.4.0 Test Group

The BC test group is the group of household members that is tested for BC eligibility. Include the following in the BC test group:

- A child under age 19 who has a qualifying relationship with the primary person, his/her spouse and any non-marital co-parent (NMCP).
- The spouse of the primary person (includes a stepparent).
- A co-parent with the primary person of a child living in the house (includes a NMCP).
- The spouse of a minor parent.
- A co-parent with a minor parent of a child living in the household.

12.5.0 Fiscal Test Group

Take those in the test group who are non-financially eligible to the fiscal test. The fiscal test group (FTG) includes all:

1. Household members who are non-financially eligible, **and**
2. Test children (12.5.3), **and**
3. Ineligible household members who are legally responsible for all person(s) listed in #1, except for those who are only legally responsible for test children.

Example. Cheryl and Eric are not married, and have a child together. Cheryl is requesting MA and BC for herself and their child, Alex. Eric is not requesting BC.

Alex is found eligible for Healthy Start. In building the FTG, Alex is a test child because he is receiving MA. Eric is not part of the FTG, because he is only legally responsible for a test child in the FTG.

Build the BC FTG around the primary person. If the only potentially eligible BC child left is a non-legally responsible relative (NLRR) child, build a separate group around the NLRR child. Take the FTG to the income tests.

12.5.1 SSI Recipients

Do not include SSI recipients in the BC test or FTG. Do not count their income.

12.5.2 MA Eligible Adults

Include the MA eligible adult in the BC FTG if s/he is legally responsible for a BC test group member. Include his/her income.

Example. Michelle is pregnant and receiving Healthy Start. She is requesting BC for her son, Steve. Michelle's income would be included in the eligibility test for BC for Steve, and she would be included in his BC FTG.

12.5.3 Test Children

Test children include the minor children that are ineligible for BC solely because of one of the following or any combination of the following:

- Are MA eligible, **or**
- Have insurance access, **or**
- Have insurance coverage, **or**

12.5.3 Test Children (cont.)

- Are ineligible for BC solely because they receive adoption assistance.

Do not count the income of the test children, but include these minor children in the FTG as test children.

When a child is on MA (other than SSI) in another case s/he can still be considered a test child in their parent's BC case if they are living in the home with them.

12.5.4 Ineligible BC Adults

Include any ineligible adult who has legal responsibility for someone who passed the non-financial test. Count their income. The exception is SSI recipients.

12.5.5 Ineligible BC Children

Do not include ineligible BC children, except for test children (12.5.3), in the FTG. Exclude an ineligible child's income.

Example. Charlene is requesting MA and BC for three of her children. She is not requesting MA or BC for one of her children, Eric. Eric's income should not be counted when determining BC eligibility for the other members of the family, and he is not included in the BC FTG.

12.5.6 Adults with Health Insurance

Include the adults (legally responsible for a BC test group member) with health insurance in the fiscal test group.

12.5.7 Exclusions

Anyone may be excluded from BC. Include the income of an excluded adult who is legally responsible for someone in the BC fiscal test group, except test children. If a child is excluded, do not count his/her income or include them in the BC FTG, unless the child is a parent of a child in the home who is eligible for BC. Excluded children include those who are non-financially ineligible for BC for a reason other than access or coverage. Examples are those who are not providing a SSN and SSI recipients.

12.5.8 Fetus

Increase the FTG size by one for each fetus a pregnant woman is carrying.

12.5.9 Temporary Absence

If the child is temporarily absent, and the parents have no other children in the home, the parents are ineligible for BC. A child can be temporarily absent and still be eligible for BC.

12.6.0 Financial

There is no asset test.

12.6.1 Assets

12.6.2 Income

Use self-declared monthly gross income when determining eligibility for a client who is **only** applying for MA or BC. If the client is applying for any other program of assistance, use the appropriate prospective budgeting technique (15.6.1). Determine the total family income by subtracting any of the following deductions that are applicable from the gross income of the household:

- $90 Work-Related Expense (15.3.5).
- Child Support Disregard (15.2.21).
- Dependent Care (17.1.2).
- Apply any other Family MA income disregards (15.0.0).

12.6.2.1 BC Applicant

A BC applicant AG's income after deductions cannot exceed 185% of the FPL (30.6.0).

12.6.2.2 BC Recipient

The income of an AG in which at least one member was a BC recipient cannot exceed 200% of the FPL (30.6.0).

12.6.2.3 Migrants

See 19.8.2.

12.7.0 Deductible Choice

When a person is determined eligible for a deductible and BC in the same month, s/he must choose between the two. Compare the total monthly BC premiums for the six-month period with the deductible for the six months. Explain the dollar amount differences to the client.

You can backdate a client's eligibility if s/he chooses a deductible. You cannot backdate BC eligibility.

12.7.1 Changing a Choice

The choice between BC and a deductible is a monthly decision. Once you confirm a choice in CARES, the choice is locked in for that month and can only change for the recurring month.

12.7.2 Deductible Met

Once the deductible is met, a client cannot change the choice to BC for the duration of the deductible.

12.8.0 Premiums

As a condition of their BC eligibility, families who are eligible with total family income that exceeds 150% FPL (30.6.0) for their group size must pay a premium in order to receive BC. The premium is calculated based on the total family income and will be no more than 3% of that income amount.

Compare the total family income (12.6.2) to the table in 30.11.0 to determine the premium. Payment or non-payment of the premium **does not** affect the eligibility of any person in the household who qualifies under a different MA sub-program (Healthy Start, AFDC-Related MA, etc.). The premium is due in the benefit month, except for initial eligibility with a free month (12.8.1).

12.8.1 Initial Eligibility

The first month is free if no one in the FTG (12.5.0) was on MA or BC in the previous month, and the BC AG has not received a free month in the previous 12 months. Consider someone with an unmet deductible as not being on MA.

12.8.1.1 Processing Timeframe

In certain circumstances, a client may need to pay his/her premium for the first and/or second month following the free month before eligibility can begin depending on when his/her application is processed. The following indicates the eligibility and timeframe for premium payments:

1. Eligibility and Processing Occur in the Month of Application.

   When an application is processed in the same month it was received, and there is a free month, the premium for the second month must be paid in advance before BC eligibility can begin.

   Example. Lisa and her family apply for MA and BC in January. They are determined eligible beginning January 1st. January is the free month. Lisa must pay the premium for her family for February before the family's BC eligibility can begin.

2. Eligibility Begins in the Month of Application – Processing Occurs in a Future Month.

   When an application is not processed within 30 days, and there is a free month, the family must pay both the second and third months' premium. CARES requires that the second and third months' premiums be paid

12.8.1.1 Processing Timeframe (cont.)

before opening when eligibility is processed any time in the third month.

Example. Cheryl and her family apply for MA on March 25th. No one in her FTG was on MA in the previous month. Her worker extends the 30-day processing time period. Her family is approved for BC on May 2nd with eligibility beginning March 1st. March is Cheryl's free month. Cheryl must pay the premium amount for April and May before BC eligibility can begin.

3. Eligibility Begins in a Future Month – Processed in the Month of Application.

   When an application is processed within 30 days and eligibility does not begin until a future month, the free month is the first future month of eligibility. The client will receive a coupon for the premium amount. S/he must pay the second month's premium by the tenth of the benefit month to remain eligible for BC. The client is responsible for paying the premium as described in 12.8.2.

Example. Arnie and his family apply for BC on April 12th. He and his family are first eligible for BC beginning May 1st. May is the free month. A coupon for Arnie's June premium is mailed out May 20th. Arnie must pay his premium by June 10th.

12.8.1.2 Previous MA/BC Eligibility

If someone in the FTG was on MA the previous month or current month, s/he must pay the first month's premium. If the first month of BC eligibility is this month or a prior month, the premium must be paid in advance before eligibility can begin. If the first month of eligibility is a future month, no advance premium is due.

12.8.1.3 Initial Premium Payment

The Economic Support Agency (ESA) collects advance payments and the worker records the payment in CARES. Payment must be either a check (personal, cashiers, travelers, etc.) or a money order. Do not accept cash. The check must be made out to 'BadgerCare'. Complete a BC premium coupon. Write in the client's Medicaid ID number on the BC premium coupon and on the check. Mail the client's initial BC premium payment (check or money order) and completed BC premium coupon directly to the BadgerCare lockbox at:

12.8.1.3 Initial Premium Payment (cont.)

BadgerCare
c/o Wisconsin Department of Health and Family Services
Box 93187
Milwaukee, WI 53293-0187

Do not co-mingle the money with other county or tribal funds. Do not combine all premiums into a county/tribal agency check.

Each agency should have a supply of blank BC premium coupons, BadgerCare Premium Employer Wage Withholding forms (HCF-13025), BadgerCare Premium Recipient/ Employer Electronic Funds Transfer forms (HCF-13026) and pre-addressed envelopes.

12.8.2 Premium Payment

Premiums can be paid by anyone. Ask the client to identify a payor when a premium is owed, and enter that information into CARES. Regardless of who pays the premium, the premium payor identified in CARES must be a household member, and is responsible for the payment of the premium. EDS uses that information when sending the first coupon. The premium month is the benefit month.

12.8.2.1 Reduced Premiums for Native Americans/ Alaskan Natives

Some Native Americans or Alaskan Natives paying BC premiums may be eligible for a reduced premium amount. The premium amount is reduced by 35.7%, which is the amount designated for the children in the household. This amount does not change regardless of the number of children in the household eligible for BC. There is no premium obligation if the only BC eligible household members are Native American or Alaskan Native children.

EDS sends corrected coupons for future benefit months for tribal members that have been identified as having a reduced premium amount. Tribal outreach workers will submit the necessary information to EDS to establish the client as eligible for a refund (12.8.2.4), which will establish the client at EDS as eligible for a reduced premium amount. Refer any clients that are potentially eligible for a reduced premium to their local tribal agency. Refer clients that have questions about the reduced premium coupons to the BadgerCare Unit at 1-888-907-4455.

A reduced premium amount will not be reflected in the CARES premium records. View adjusted premium amounts on the BD screen on MMIS.

12.8.2.2 Payment Method

When requested, EDS will provide clients with instructions for choosing the payment method they want. Clients can contact the BadgerCare Unit, 1-888-907-4455.

The payment methods are:

- Direct payment by check or money order.
- Electronic Funds Transfer (EFT).
- Wage withholding from each paycheck received. (Unlike Child Support, there is no statutory requirement that the employer participate in BC premium wage withholding. If the employer decides not to participate, the client will have to choose direct pay or EFT.)

Provide clients with the Wage Withholding (HCF-13025) and EFT (HCF-13026) forms to allow the client to choose a payment method other than direct payment. Instruct the client to mail the completed forms to the address listed on the forms once s/he has chosen a payment method. Since it takes some time to set up EFT and wage withholding, the client pays directly until EDS informs them otherwise.

12.8.2.3 Advance Payments

Payments can be made in advance (further than the next month), but the payment cannot exceed the current certification period.

If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial monthly payments). If the income amount changes, recalculate the premium. The client will be notified through CARES that his/her premium amount has changed. If the premium amount has decreased, EDS will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the client will receive a coupon with the new premium amount. If the premium coupons have already been sent, the client will need to pay the additional amount owed. The client will not receive a coupon for the difference that is owed.

12.8.2.4 Refunds

Contact the BadgerCare Unit to issue a refund if the premium was paid in advance if the premium is for one of the following:

1. A month that the AG was ineligible for BC.

12.8.2.4 Refunds (cont.)

2. A month that the AG's budgetable income drops to or below 150% of the FPL (30.6.0) and the income change was reported within ten days of the date the change occurred.

3. A month which requires a lower premium amount due to a change in circumstances which was in effect for the entire month so long as the change was reported within ten days of the date it occurred. The lower premium amount due is the first day of the month in which the change was reported. A refund for the difference will be issued.

Native American/Alaskan Native Premium Refunds
Native Americans or Alaskan Natives paying BC premiums can receive a refund of the portion of the BC premium that is designated for children in the household. The refund is 35.7% of the premium amount, regardless of the number of children in the household eligible for BC. If a premium has been paid for a case in which the only eligible household members are Native American or Alaskan Native children, a full refund of the premium amount will be made. EDS will send corrected coupons for future benefit months for those tribal members that have been identified as having a reduced premium amount.

Those who are eligible to receive a refund of part, or all, of their BC premium must meet **all** of the following criteria:

1. Have a child in the household who is:

   - A Native American or Alaskan Native tribal member, **or**

   - A natural or adoptive child of a Native American or Alaskan Native tribal member, **or**

   - Possesses a letter identifying the child as a descendant of a Native American or Alaskan Native tribal member, **or**

   - A natural or adoptive child of a household member that possesses a letter identifying the child as a descendent of a Native American or Alaskan Native tribal member, **and**

2. Have a child in the household who is eligible for BC, **and**

3. Have paid a premium for BC sometime after July 1, 1999.

12.8.2.4 Refunds (cont.)

Tribal outreach workers will submit the necessary information to EDS to establish the client as eligible for the refund. Refer any clients who are potentially eligible for this refund to their local tribal agency.

A reduced premium amount will not be reflected in the CARES premium records. View adjusted premium amounts on the BD screen on MMIS.

Do not issue notices regarding the refunds or reduced premium amounts. Refer clients that have questions about the status of a refund and/or a reduced premium amount to the BadgerCare Unit at 1-888-907-4455.

12.8.3 On-going Payment

On-going premium payments are sent directly to the BadgerCare lockbox at:

BadgerCare
c/o Wisconsin Department of Health and Family Services
Box 93187
Milwaukee, WI 53293-0187

Checks are made out to 'BadgerCare'. BC premiums are due on the tenth of the benefit month, no matter which payment method is chosen. For families who have chosen 'direct pay' as their payment method, EDS sends out the BC premium coupons on the 20th of the month before the benefit month. EFT occurs on the third business day of the benefit month.

12.8.4 Late Payment

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Clients must pay the overdue payment(s) that closed the case, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example. If the client owed a premium for September, and does not pay it until October, then s/he will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

Between Due Date and Adverse Action of the Benefit Month

The case will stay open for the benefit month even if no payment is received by the due date. It will close at the end

12.8.4 Late Payment (cont.)

of the benefit month if no payment is received by adverse action in the benefit month.

Between Adverse Action of the Benefit Month and the Last Day of the Benefit Month
If the client pays between adverse action of the benefit month and the last day of the benefit month, s/he can reopen. Run SFED with dates and confirm.

Example. Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He pays on September 26th. The case closed effective September 30th. Run with dates to open for October. Then run without dates for November eligibility.

Anytime in Month After the Benefit Month
If the client pays any time in the month after the benefit month, s/he can reopen. S/he must pay the premium that closed the case. If s/he owes a premium for that following month, s/he must pay that premium before CARES will open BC. The client must pay you directly (not EDS). You can check with EDS to see if a premium has already been collected for that month.

When you get the payment(s), record the payment in CARES and run SFED for the benefit month and confirm. Then run SFED for the following month, and confirm.

Example. Adverse action is September 16th. Jim has not paid his September premium by September 16th. He finally pays on October 26th. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. To reopen the case, run SFED for October and confirm. Finally, run SFED for November and confirm. (The November premium is not due until November 10th and does not have to be paid in advance.)

Two Months After the Benefit Month
If the client pays in the second month after the benefit month, it's a non-payment (12.8.5).

12.8.5 Non-Payment

If the BC AG does not pay the monthly premium by adverse action in the benefit month, apply a restrictive re-enrollment period (RRP), unless there is good cause (12.9.2). The RRP begins with the first month of closure. If a late payment is

12.8.5 Non-Payment (cont.)

received by the end of the month after the benefit month, lift the RRP.

12.8.5.1 Insufficient Funds

You will be notified with an 056 “Run SFED/SFEX” alert in CARES if a BC client pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. Apply a restrictive re-enrollment period (RRP), unless there is good cause (anything beyond the client’s control), and close the case. The RRP begins with the first month after closure. Determine if an overpayment exists, and process the overpayment (12.10.2).

12.8.6 Changes

Lower Premium - When a change is reported that results in a lower premium amount, confirm eligibility for the entire AG. EDS will refund any excess premium that was paid. The effective month of the lower premium is the month in which the change occurred or the month in which it was reported, whichever is later.

Higher Premium - When a change is reported that results in a premium for the first time or a higher premium, you must give notice to the client. CARES will not allow you to confirm if the notice requirement cannot be met. The increase is effective the following month if BC eligibility is confirmed before adverse action. If the change is confirmed after adverse action, the increase is not effective until the month after the following month.

Example. Jessica has BC with a premium for her and her family. She reports a change in income to her worker on April 23rd that results in a higher premium amount. Jessica’s premium will not increase until June 1st. She will receive the coupon for the new premium amount at the end of May.

12.8.6.1 Person Adds

Lower Premium - When adding a person to the group results in a lower premium, add the person to the group on CARES and confirm eligibility for the whole AG. EDS will refund any excess premium that was paid.

Example. A child with no income is added to the group. The group’s income is now below 150% FPL (30.6.0) so it no longer owes a premium. EDS will refund the premium.

Higher Premium - You must give a notice to the client when adding a person to the group causes the group to pay a

12.8.6.1 Person Adds (cont.)

premium for the first time or to pay a higher premium. CARES will not allow you to confirm if the notice requirement cannot be met. Certify the new person by completing and returning the 3070 for the period you cannot confirm eligibility in CARES.

- Mail: EDS
  P.O. Box 7636
  Madison, WI 53707
- E-mail: eds_3070@dhfs.state.wi.us
- Fax: (608) 221-8815

The increase is effective the following month if the person add was before adverse action.

Example. Mike was added to Rachel's case on June 6th (before adverse action). His income caused a premium increase. The increase is effective July 1st. Certify Mike's BC eligibility effective June 6th by sending in a 3070 for the dates between June 6th and June 30th.

If the person add was after adverse action, the increase is not effective until the second month.

Example. Ann was added to the case on December 22nd (after adverse action). Her income caused a premium increase. The increase is not effective until February 1st. December and January premiums are correct. Certify Ann's BC eligibility effective December 22nd by sending in a 3070 for the dates between December 22nd and January 31st.

12.9.0 Restrictive Re-Enrollment Period (RRP)

An AG who owes a premium for the current month who leaves BC by quitting or not paying a premium may be subject to a restrictive re-enrollment period. A restrictive re-enrollment period (RRP) means the BC AG cannot re-enroll in BC for six months from the termination date.

Example. The client had an income increase which leads to a November premium. Previously she did not owe a premium. S/he tells the worker October 20th, (after Adverse Action), that s/he does not want BC for November. Since the client does not owe a premium in October, s/he does not receive an RRP, even though s/he will receive an

12.9.0 Restrictive Re-Enrollment Period (RRP) (cont.)

additional month of BC in November. (It is too late to close BC for November.)

Note: If she does not pay the November premium, she will have to pay it before she can be eligible for BC again (12.8.4).

For this same case, the client does not tell the worker until November 2nd that they do not want BC for November. Since the client owes a premium in the current month of November, s/he does receive an RRP beginning in December.

12.9.1 Good Cause for Quitting BC

Do not apply the RRP when an AG who owes a premium for the current month voluntarily quits BC for these reasons:

- No person is non-financially eligible for BC.
- The AG moved out of Wisconsin.
- Health insurance became available for the AG.
- Entire AG is now MA eligible.
- The AG has an increase in income that makes them BC ineligible.

12.9.2 Good Cause for Non-Payment

Good cause reasons for not paying the BC premium are:

- Problems with the financial institution.
- System problem.
- Local agency problem.
- Wage withholding problem.
- Fair hearing decision.

The client must still pay the arrears before eligibility will begin again.

12.9.3 Household Changes

End the RRP when an adult member of the former BC AG leaves the home during the RRP for one full calendar month. Begin BC eligibility the first of the month after the month the adult left. The BC AG must pay any arrears before eligibility starts again. The AG does not have to make payments for months they were ineligible.

Example. Dad leaves the home on May 20th. On June 20th he has been out of the home a full calendar month. Mom and the kids may be BC eligible starting July 1st.

12.9.4 Reapplying

An AG who applies for BC before the end of the RRP is ineligible. The AG must serve the full six-month penalty period. Eligibility may begin again in month seven. Exceptions are found in 12.9.1, 12.9.2 and 12.9.3.

S/he must pay all arrears for months s/he was eligible. After the client has been off BC for 12 months, the arrears are forgiven.

12.10.0 Administration

Clients have the right to a fair hearing, timely case decisions, and accurate notices of decision. See the IMM for specifics.

12.10.1 Notices

A client must receive a notice at least ten days prior to the negative action such as closing or an increase in premium. If the premium will increase and the notice requirement cannot be met, CARES will not allow you to confirm the increase.